Main Street Medical Center
369 N. Main Street Crestview, FL, 32536 · Office (850) 398-6963 · Fax (850) 398-8277

PATIENT FINANCIAL RESPONSIBILITY & NO SHOW/LATE ARRIVAL POLICY

Patient Name: _____ Date of Birth: _____

Name of responsible party/Policy Holder: _____

Relationship to patient: _____ Date of Birth: _____

Contact Number: _____ SSN#: _____

Address Responsible Party: _____

If you have health insurance, a copy of your insurance will be kept on file. It is the patient's responsibility to notify our office of any changes to the policy. **All patient co-payments are due on the day of patient appointment. We can only estimate your co-payment, which will be $20 unless specified on your insurance card. We do note receive any guarantees, from the insurance company, of payment until after claims are reviewed.**

No Show/Late Arrival Policy: Effective August 1, 2008 - We understand that situations arise and you may not be able to make your appointment or that you are unexpectedly running late to your appointment. Courtesy calls of 24 hours in advance for cancellations and notice that you are unexpectedly running late, will help us eliminate increased wait times and costs. We strive hard to keep our patients costs and wait times low, but increased no shows and late arrivals will lead to overbooking of physician schedules.

Charges:

1st No Show: $25

2nd No Show: $50

3rd No Show: $75

4th No Show: Discharge from Practice

I have read and that I understand the above information to the best of my knowledge. I understand that providing incorrect information could result in non-coverage by my health insurance company. I agree to be responsible for the payment of all services rendered on my behalf or dependants. I understand that payment is due at the time of service and in case of default; patient may be dismissed by practice, and will be responsible for reasonable attorney's fees and all costs of collections. Payment options are available should assistance be required. There will be a $30 charge for all returned checks. I understand the No Show Policy and charges that are associated with not showing up for my appointment without a courtesy call of cancellation.

I, the patient, have been informed of my financial responsibilities and agree to comply with this policy.

_____ _____

Patient Name (printed) Date

_____

Signature of Responsible Party